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in the

Supreme Court

of the

United States

OCTOBER TERM, 1972

NO. A-12

DISPOSABLE SERVICES, INC.,
Petitioner,

vs.

ITT LIFE INSURANCE COMPANY
OF NEW YORK,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS, FIFTH CIRCUIT

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MAY IT PLEASE THE COURT:

Your Petitioner, DISPOSABLE SERVICES, INC., prays that a Writ of Certiorari issue to the United States Court of Appeals, Fifth Circuit, to review the above cause.

OPINIONS BELOW

The opinion of the United States Court of Appeals is reported at 453 Fed 2d 21. The opinion appears in Appendix A to this Petition. Their denial of rehearing, with short dissenting opinion of Justice Godbold, is published at 457 Fed 2d 972. This appears in Appendix B hereto.

JURISDICTION

The date of the judgment of the United States Court of Appeals sought to be reviewed is December 30, 1971, which judgment reversed a judgment for the Petitioner in the United States District Court for the Southern District of Florida. The Court of Appeals entered judgment on April 21, 1972, after denying a timely Petition for Rehearing on April 13, 1972. Appended hereto and marked Appendix C is the judgment of the United States Court of Appeals sought to be reviewed.

Appended hereto and marked Appendix B is a copy of the Order and Opinion of the United States Court of Appeals denying rehearing.

Timely application was made by Petitioner to the United States Supreme Court for extension of time for applying for Writ of Certiorari in this cause, and this Court did extend the time for filing this Petition to and including September 10, 1972.

Jurisdiction of this Court is invoked under 28 USC §1254 (1).

QUESTIONS PRESENTED

1. Whether the judgment of the United States Court of Appeals reversing the Trial Court's directed verdict in favor of Petitioner and entering a Judgment on the insurance policy in favor of the Respondent conflicted with applicable local law in such a way as to require certiorari, to issue, to review the Judgment and to vacate the same.

2. Whether the United States Court of Appeals below, after reversing the Trial Judge on his Order directing a verdict for the Petitioner, should have remanded the cause for jury determination of conflicting issues of fact, and whether the failure to do so is a denial of Petitioner's constitutional right to trial by jury and whether by so doing the Court departed from the accepted and usual course of judicial proceedings.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

(1) The United States Court of Appeals has decided an important State question so as to conflict with State law and with §627.01081, Florida Statutes.

§627.01081, Florida Statutes, provides as follows: "All statements and descriptions in any application for an insurance policy or annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and in-

correct statements shall not prevent a recovery under the policy or contract unless either:

(1) Fraudulent; or

(2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or

(3) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate, or would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise."

(2) The decision of the United States Court of Appeals in failing to send this cause back to the Trial Court for jury determination and in rendering judgment on the law for the Respondent after reversing the order of the Trial Judge directing a verdict for the Petitioner, was violative of the 7th Amendment to the Constitution of the United States.

VII AMENDMENT TO THE CONSTITUTION OF THE UNITED STATES

"Civil trials:

In suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law."

STATEMENT OF THE CASE

In November, 1969, one Samuel Britt, now deceased, was the secretary and the owner of 3% of the common stock of the Petitioner corporation. He continued to be the officer and owner until the date of his death on May 24, 1970.

Prior to that time, on or about November 11, 1969, Britt applied to the Respondent insurance company for a life policy in the amount of $75,000.00 and designated the Petitioner to be the owner and beneficiary of the policy. The application contained a provision that it was to be effective at the time of payment of the first premium.

At the same time, Britt completed various portions of the Respondent's application relating to his medical history and gave a statement that at the time of the application, he was in good health.

The only medical history that Britt had at that time was an appendectomy in 1954, a bee sting on his left arm and general good health throughout his lifetime.

At the request of the Respondent, Britt was examined by one Dr. David A. Sommer, a physician designated by the Respondent. The physician conducted whatever examination of Britt Respondent thought was necessary, and also inquired of him the facts concerning his previous medical history. As a result of the examination, a life insurance policy was issued by Respondent on December 11, 1969. The policy bears the date of December 9, 1969, has the number 21576, and was delivered to the Petitioner as beneficiary shortly thereafter. It contained no clause

providing that the insured be in as good health at the effective date as he was at time of application for insurance.

Some time thereafter, the Respondent returned the original application for insurance to Britt and the Petitioner and requested the signature of an officer of the Petitioner corporation other than the deceased, Samuel Britt. The properly signed application, bearing all required signatures, was returned to Respondent on or about January 14, 1970. On February 3, 1970, Britt contacted a certain Dr. Henry Bryant of Coral Gables, Florida, in reference to his back pains. He had seen Dr. Bryant shortly before for treatment of a laceration of his eye incurred as a result of an accident in his home. Britt complained about back pains, the doctor examined him, found tenderness in his left flank over the kidney area, and recommended that Britt go to the hospital and be checked in to find out the cause. (Original transcript — 120). Britt was essentially normal except for the tenderness in his left flank. (Original transcript — 121). Britt told the doctor that he had had this pain for a few days, that he was unable to sleep, that he had the flu, and that he had lost weight over the last few months. The doctor was unable to reach a diagnosis, and could not tell Britt exactly what his problems were. On February 5, 1970 Britt entered the hospital. (Original transcript — 122, 133-135). Tests were made of him, x-rays were taken, and eventually an operation was performed to find out what the problem was. (Original transcript — 123). At that time, it was found that he had a carcinoma of his pancreas. The doctor was unable to tell Britt until February 11, 1970 that he had a tumor and that his kidney was out. (Original transcript — 131).

On February 5, 1970, Britt forwarded a premium check in payment of the life insurance policy to the Respondent. This was a check drawn on the account of the Petitioner, on which Britt had power to sign as an officer of the Petitioner. The check was received by Respondent a few days thereafter.

After Britt was operated upon, a period of recovery ensued and he was subsequently discharged from the hospital. Thereafter, he was readmitted to the hospital and eventually died on May 24, 1970. On May 28, 1970, Respondent was notified of Britt's death and shortly thereafter a written proof of loss was filed with the Respondent. No payment has been made to the Petitioner as the beneficiary under the policy.

At the conclusion of all the evidence presented by Petitioner and Respondent in the trial court, the United States District Judge, Peter Fay, on March 9, 1971, by directed verdict, rendered a judgment for damages in favor of the Petitioner in the principal amount of $75,000.00 with costs, interest, and attorneys fees. Federal jurisdiction was based on diversity of citizenship.

Appeal was taken to the United States Court of Appeals for the Fifth Circuit, and that body on December 30, 1971, issued its opinion reversing and rendering and holding that the Respondent insurance company was entitled to a judgment on the policy as a matter of law. The Court held that the insured Britt became aware of a serious change in his physical condition which rendered several of his statements relative to his health in his application for insurance no longer true, that he had a duty to disclose the same prior to the effective date of

the policy, and that his failure to do so vitiated the policy under Florida Statute 627.01081.

Rehearing from the order of reversal was denied with a dissenting opinion by Justice Godbold.

From that order of reversal and that denial of petition for rehearing, this writ is sought.

REASONS FOR GRANTING THE WRIT

(1) The decision of the United States Court of Appeals has decided an important State question in a way in conflict with applicable State law.

For sake of continuity, we restate Florida Statute 627.01081:

> "All statements and descriptions in any application for an insurance policy or annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealments of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless either:
>
> (1) Fraudulent; or
>
> (2) Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or
>
> (3) the insurer in good faith would either not have issued the policy or contract,

> or would not have issued it at the same premium rate, or would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise."

The decision of the United States Court of Appeals in this cause interpreted Florida Statute 627.01081, first interpreted by the Florida Supreme Court in **Life Insurance Company of Virginia vs. Shifflet**, Fla. 201 So.2d 206, (1967), later modified by the Florida Supreme Court in **National Standard Life Insurance Company vs. Permenter**, 204 So.2d 206 (Fla. 1967). It did so incorrectly, and greatly extended the **Shifflet** rule, and by its holding directly conflicted with **Permenter.**

In **Shifflet**, the Florida Supreme Court initially held

> "We hold misrepresentations in an application for insurance material to the acceptance of the risk, **do not have to be made with knowledge of the incorrectness and untruth to vitiate the policy**". (Emphasis supplied.) 201 So.2d at 719.

> "We accord the statute its plain and obvious meaning and hold recovery under the policy is precluded if the misrepresentation is material to the acceptance of the risk **or if the insurer in**

> **good faith would not have issued the policy** in the terms it was issued." (Emphasis supplied.) 201 So.2d at 719.

Shortly thereafter, in **Permenter**, the Florida Supreme Court expressed concern that the "pronouncement in **Shifflet** may be too sweeping in scope and may lend itself in application, where literally to do so it would work injustice", and laid down more narrow guidelines. In this cause, by broadening the scope of **Shifflet**, and departing from **Permenter**, an injustice has in fact been worked. The United States Court of Appeals here in noting **Permenter** quoted as follows from Justice Ervin:

> "An incorrect statement in order to be material and vitiate a policy must be one given by the insured in response to a question he understood or reasonably should have understood, or one which reasonably he could be expected to have sufficient information to answer or state he lacked knowledge to give a responsive answer.
> "Each situation where an alleged misrepresentation or incorrect statement is advanced to vitiate a policy should be examined to determine whether under the particular circumstances the applicant reasonably could be held responsible for the incorrect statement and without fault on the part of the insurer." 204 So.2d at 206, 207.

The Court of Appeals did not further examine **Permenter** or it would have found additional language totally

justifying the Trial Court's order directing a verdict, where it found as a fact that the insured, Britt, did not know or believe that he had a condition more serious than a back pain. Ignored by the Court of Appeals was the following language from Justice Ervin:

> "—Think, for example, of the numerous situations in which an applicant is asked by the insurer or its agent to respond to questions which require or call for in one way or another, statements that amount to matters of opinion or judgment. In such cases where an applicant responds to such questions, many times posed in series, his answers made in good faith and without intent to deceive should not automatically in all cases have the effect of voiding the policy should one or more turn out to be an erroneous expression of opinion or judgment. In the area of health, an applicant may express an erroneous opinion concerning a specific question relating to his health of which he has no medical knowledge and which could only be answered by a medical expert after diagnosis or examination. However, cases involving excusable statements of judgment or opinion should not be analogized to those where an applicant makes careless or reckless statements positively as true when he has no knowledge as to whether such statements are in fact true, and as a fair and reasonable man should have indicated he was without sufficient knowledge to give an answer." (Emphasis supplied).

The **Permenter** rule above expressed was followed by the Florida Supreme Court in **Tucker vs. Travelers Insurance Company**, 233 So.2d 198, (Fla. 1969).

The United States Court of Appeals on this matter stated that even under the **Permenter** case by case approach, it could find for the Respondent since the insured, Britt, was aware of a serious change in his health prior to the effective date of the policy. This interpretation is incorrect since one of the exceptions indicated by Justice Ervin in that case pointed out that if an applicant for insurance erroneously, but in good faith, had an opinion, on the information available to him that his condition was not serious, that the contract would not be vitiated.

The language of the Court of Appeals in its opinion is ambiguous as to whether in its view of the facts, it meant that the insured Britt was aware of a change in his physical condition which later events proved to be serious, but that on February 5, 1970 he did not know the change in his condition to be serious, or whether he was aware of a physical change and was also aware of its serious nature at the same time.

There is, of course, an important difference, and, under the former view, **Permenter** would not vitiate the policy.

The particular language relied on by the Petitioner from **Permenter** is:

> "in the area of health, an applicant may express an erroneous opinion concerning a specific question relating to his health of which he has no

medical knowledge and which could only be answered by a medical expert after diagnosis or examination".

Thus, in this cause, under **Permenter**, if Britt, on February 3rd, in good faith, though erroneously, based on the information he had, believed that his condition was not serious, and such erroneous belief was reasonable, and not reckless, then he was entitled to recover under the policy. Such was the view of the Trial Judge based on the evidence.

It is important also to note that **Shifflet** and **Permenter** both dealt specifically with misrepresentations in answers to questions in applications. The United States Court of Appeals in this case extended both **Shifflet** and **Permenter** to cover a duty to disclose later material changes in health, after the application was completed, accepted, and the policy delivered to the insured.

To set the record straight, in **Shifflet**, the insured had unknowingly incorrectly answered the following questions in his application for insurance:

"Q. What physicians, including specialists, have you consulted during the past five years?

"A. None.

"Q. Have you ever had or been treated for: Heart disease, angina pectoris, palpitation shortness of breath, high blood pressure?

"A. No."

The question certified to the Supreme Court of Florida and answered by it was as follows:

"STIPULATED QUESTION

"WHETHER CLEARLY INCORRECT AND UNTRUE STATEMENTS TO QUESTIONS ON AN INSURANCE APPLICATION, MATERIAL TO THE ACCEPTANCE OF THE RISK OF THE CONTRACT, MUST BE GIVEN WITH KNOWLEDGE OF THE INCORRECTNESS AND UNTRUTH TO VITIATE THE POLICY UNDER SECTION 627.01081 (2) FLORIDA STATUTES, F.S.A.?"

Thus, **Shifflet** dealt with a nonintentional misrepresentation to an insurance company in an application, by questions clearly answered incorrectly and untruly.

This is not the instant case at all. Here there were no misrepresentations by Britt in the application whatsoever. There is no evidence that he had any kidney problem or cancer at the time of making his application in November of 1969; in fact, the evidence was to the contrary. The policy was delivered to Britt in December 1969. Negotiations had ceased, and the Company was satisfied with Britt's application. For the policy to become effective, one ministerial act had to be accomplished by the insured; i.e., to mail a check in payment of the premium.

In this case at hand, the Court of Appeals made a strained interpretation of Florida Statute 627.01081 stating

"Non-recoverability under the Florida Statute is not predicated solely on misrepresentations made in the application. Any such misrepresentation, omission, concealment of fact or incorrect statement occurring at any time during the period of negotiations between the parties operates to preclude recovery if any of the conditions shown in Sections (1) through (3) of the quoted Florida statute exists. Until the first premium was paid the parties were still legally in the process of negotiating.

On February 3rd, at least two days before the contract under its own terms would have become effective, Britt became aware of a serious change in his physical condition which rendered several of his statements relative to his health, no longer true.

His failure to inform ITT of his physical condition as he was aware of it on February 3rd and later—whether such failure is characterized as a passive misrepresentation, omission or concealment of fact—vitiated the policy under Florida Statutes inasmuch as his condition was one material to the acceptance of the risk and because of which condition ITT would have refused coverage at that time (had they known about it)."

By this holding, the Court of Appeals broadened **Shifflet** in two ways. First, by its interpretation of the phrase "any negotiations therefor" set out in Florida Statute 627.01081 as follows:

> "All statements and descriptions in any application for an insurance policy or annuity contract, or **any negotiations therefor,** by or on behalf of the insured or annuitant, shall be deemed to be representations and not warranties."

In order to bring this case under **Shifflet**, the Court expanded the scope of the Statute by interpreting "any negotiations therefor" to mean any misrepresentation, omission, concealment of fact and incorrect statement, as precluding recovery, under other terms of the Statute, if they occurred from the date of the application up to and including the effective date of the policy. In this particular case, negotiations, as that term is commonly understood in business, and in contract law, had in fact ceased in December, 1969, when the application for insurance was accepted and the policy delivered.

Second, the Court extended **Shifflet** to include an affirmative requirement that a prospective insured correctly evaluate that he had a material change in his health, if in fact he had such change, and disclose said change to the insurance company, even after his application had been completed, accepted and the policy had been delivered up until the effective date of the policy. The facts in **Shifflet**, as aforementioned, encompassed only misrepresentations in answers to questions in applications.

Also, by its holding, the Court conflicted with **Permenter**, tacitly overruled **Permenter**, and left no exclusion from the harsh **Shifflet** rule for a good faith, reasonable but erroneous, opinion by an applicant for insurance as to his health and whether or not it had materially changed.

This is clearly error. If the Florida Legislature had wished to extend the language of Florida Statute 627.01081 to include more than misrepresentations, etc., in applying for a policy and in negotiations for a policy, it would have plainly said so, and would have covered representations made up to the effective date of the policy. It did not do so, and the United States Court of Appeals, Fifth Circuit, by its holding herein, has wrongfully extended the scope of Florida Statute 627.01081 in a manner not intended by the Florida Legislature and in a manner clearly detrimental to thousands of Florida policy holders.

The effect of its decision is to require an applicant to know that a new health problem which he has incurred before the effective date of his policy is one of such a serious nature that his insurance company would not have insured him if it had been apprised of said problem prior to the time it accepted his application, delivered his policy, and asked for its money.

By this standard, an applicant with a high threshhold of pain who did not feel serious pain and thus regarded his physical health as not seriously altered or impaired would not be covered because, in fact, as it later developed, his health proved to have been seriously impaired.

In the instant case, the Court of Appeals has extended and magnified **Shifflet**, conflicting with the express desire of the Florida Supreme Court in **Permenter**, to limit its scope.

As Justice Ervin said in **Permenter**,

> "My specific concern is that our pronouncement in **Shifflet** may be too sweeping in scope and may lend itself to application where literally to do so would work injustice."

As the Florida District Court of Appeals, Fourth District said in **Tucker**, paraphrasing Justice Ervin

> "He then cited examples in which opinions or judgments of the applicants were required to answer questions on insurance applications. He did not feel that if such a question was material and answered wrong but in good faith, that it should vitiate the policy."

The United State Court of Appeals here has conflicted with the expressed opinions and intent of the Florida Supreme Court and its District Court of Appeals on this question of local law with grave potential for innocent policy holders as aforesaid. The extension of **Shifflet** is unwarranted and should be set aside—so should the conflict with **Permenter.**

The above stated extension of **Shifflet** and conflict with local Florida law in **Permenter,** is sufficient ground for this Honorable Court to accept certiorari. There is, of course, ample precedent for the same.

In the leading case of **Rosenthal vs. New York Life Insurance Co.**, 304 U.S. 263, 82 L.Ed. 1330 (1938), the Circuit Court of Appeals had decided the questions presented—the cancellation of reinstatement of an insurance policy on grounds of fraud—as a matter of general law according to the view of that Court of the weight of authority.

Petitioners sought a rehearing upon the grounds, among others, that the interpretation of the policy was governed by the law of Missouri. The Court said:

> "While respondent contends that the decision below is not in conflict with the local law, it is not necessary for us to determine that question. It is enough to say that the questions to be decided are those of state law and should have been determined according to the decisions of the state court. **Erie Railroad v. Tompkins**, 304 U.S. 64; **Ruhlin v. New York Life Insurance Company**, 304 U.S. 202.
>
> "Certiorari is granted, the judgment of Circuit Court of Appeals is vacated, and the cause is remanded to that court for further proceedings in conformity with this opinion."

It is so in the instant case. Here, the United States Court of Appeals Fifth Circuit contended that its finding squared with **Permenter** as well as with **Shifflet** but they did not. It broadened the scope of **Shifflet**, then treated **Permenter** as equally broadened. Applicable local Florida law, as it existed, should have been applied—not as expanded by the United States Court of Appeals Fifth Circuit.

For this reason standing alone, certiorari should be granted with an order of reversal and other appropriate relief.

(2) **The decision of the United States Court of Appeals below sanctioned a departure from the accepted**

and usual course of judicial proceeding and violated the 7th Amendment to the United States Constitution, in that after reversing the Trial Judge below on his Order directing a verdict for the Petitioner, instead of remanding the cause for jury determination, the Appellate Court entered judgment for the Respondent denying the Petitioner its constitutional right to trial by jury under the 7th Amendment.

The action of the Court of Appeals in extending **Shifflet**, and impliedly or tacitly overruling **Permenter**, contra to the Florida Supreme Court's holdings, are reason enough for granting certiorari—but that was not its only failure herein to accord substantial justice, nor only manner by which it departed from the accepted and usual course of judicial proceeding.

If said Court of Appeals found that the Trial Judge erred as a matter of law in directing a verdict for the Petitioner, it should have sent the case back to the Trial Court for a jury determination of the issues of fact surrounding the insured Britt's knowledge of his ailment on February 3, 1970, his knowledge of its seriousness, and the materiality of the facts known to him at that time.

Clearly, the Trial Judge found that Britt's knowledge of his condition on February 3rd was limited to the fact that he had a back pain, had lost weight, and was to go to the hospital to be checked. This was his first visit to a doctor in reference to this new condition.

The Trial Court found no evidence elicited to show bad faith or misrepresentation. The Appellate Court then reevaluated the evidence and substituted itself and its

view of the evidence for that of the Trial Court. If the Appellate Court found that there was evidence to be reconsidered, then this evidence of necessity must be considered by a jury and not by the Appellate Court.

The following references to the original transcript bear out the Trial Court's findings of fact on this point:

"T-247
"THE COURT: It may be serious to the man, but where in here or where does any case or any policy provide or require that he tell you that he went to the doctor with a backache, which is all he had on the third?"

T-256
"THE COURT: This is what I come back to, you see. Nobody in this case has made any misrepresentation to your company."

T-265
"THE COURT: As I say, I have a real problem with the evidence because Dr. Bryant certainly did not say the man knew he was seriously ill."

T-282
"THE COURT: But it takes a few months for cancer to develop. There is no testimony that the man knew he had or could have known he had cancer."

T-284
"THE COURT: There is not one scintilla of evidence that anyone in this case ever made a misrepresentation..."

T-292
"THE COURT: I will rule as a matter of law that there are no issues under that Statute 627.01081."

T-294
"THE COURT: There is no evidence in this case that Mr. Britt or anyone else on behalf of the Plaintiff made any misrepresentations in the application for this policy. There is not one scintilla of evidence."

T-296
"THE COURT: Right, and he did not think he had cancer.

MR. CUSICK: That is not the question. The question is whether he had it.

THE COURT: I disagree. That is going to open up a whole new area. Maybe you will be successful. If you are, you are going to provide a beautiful defense on thousands of insurance policies that I think were written in good faith by both sides taking that as one of the gambles. That is all built into the mortality tables, Counsel."

T-298
"THE COURT: I may be wrong, but I am going to grant the Plaintiff's motion for a directed verdict because I know of no evidence, and will state again for the record in this case, where any reasonable man could disagree on the fact that there were no misrepresentations made in the application or in this policy."

Moreover, the Court of Appeals in its opinion did an astounding thing. It substituted its own findings of fact on the point of the insured's knowledge of his ailment on February 3, 1970, for that of the Trial Judge, without openly stating that they differed from him in interpreting the evidence, or giving any reasons for rejecting his findings of fact on this point. The Court of Appeals said on the disputed issued, Page 4, United States Court of Appeals opinion of December 30, 1971—Appendix A

> "It is undisputed that on February 3rd, Britt was informed by Dr. Bryant that in his professional opinion, Britt was suffering from some type of kidney ailment, probably a kidney stone, which required hospitalization for additional tests".

As to this question, Justice Godbold of the United States Court of Appeals, dissenting from the order denying the Petitioner a rehearing, stated at page 3, United States Court of Appeals order of April 13, 1972, denying rehearing, — Appendix B:

> "The ultimate concern is whether Britt, the insured, had such knowledgment of an impairment to his health as put on him a duty to report it to the insurance company. This brings us face to face with the question of what Britt learned of his condition from Dr. Bryant on February 3, a date which, under any version of the facts, was before the policy became effective. Dr. Bryant testified that at no time did he diagnose Britt as

having a kidney stone, that he examined Britt and found him essentially normal except for tenderness over the left kidney, that he thought there was something wrong with the kidney, either an obstruction or infection, and recommended to Britt that he check in to the hospital and find out the cause, and that at some point (the time of which is not fixed) he indicated a "possible" kidney stone.

"An entry on the hospital admission record, made by a resident physician who did not testify, said this:

> 'Pt. states that about nine days ago he started (with) pain in the back (on the left). It was a sore (sic) in the beginning and it increased until being very strong. With heat pad he improved. Three days ago he saw his doctor and he thought that probably a kidney stone was the cause and he must be admitted.'

"The entry is ambiguous — whether the second "he" is the doctor or Britt is unclear. In any event, ambiguous or not, taking both the hospital record and Dr. Bryant's testimony, it is plain that our original opinion was wrong in stating that it was "undisputed" that Dr. Bryant told Britt that he "was suffering from some type of kidney ailment, **probably** a kidney stone." (Emphasis added.)

Petitioner is in complete accord.

Findings of fact by a Trial Court are conclusive on Appeal if there is sufficient evidence in the record to support those findings and they are not clearly erroneous. **Crane vs. Crane,** 254 So.2d 860.

If there is sufficient evidence in the record to support the findings of fact, an Appellate Court must uphold said findings even though it might have decided differently itself—if it had been in the position of the Trial Judge. **Brenner vs. Smullian,** 84 So.2d 44.

This is general law, Federal law and Florida law. The Court should have followed it and sent the cause back to the District Court for jury trial on the disputed issues of fact. Its failure to do so substantially departs from normal judicial process and, in addition, denies the defendant the jury trial to which the 7th Amendment of the United States Constitution entitles him.

An analogous situation where certiorari was granted is **National Labor Relations Board vs. Waterman S.S. Corp.,** 309 U.S. 493 (1940).

In that case, the NLRB made certain findings of fact which the District Court and Circuit Court of Appeals failed to follow on the grounds that the Board's order was not supported by substantial evidence and was based on mere suspicion. The Board contended that under the Act, findings of the Board as to facts, if supported by evidence, shall be conclusive.

The Supreme Court of the United States reversed and remanded with instructions to reinstate the Board's order in its entirety. The Court said:

> "The Court of Appeals' failure to enforce the Board's order resulted from the substitution of its judgment on disputed facts for the Board's judgment—and power to do that has been denied the courts by Congress. Whether the court would reach the same conclusion as the Board from the conflicting evidence is immaterial and the court's disagreement with the Board could not warrant the disregard of the statutory division of authority set by Congress."

In the instant case, it is not an Act of Congress which denies the Circuit Court of Appeals the right to substitute its own judgment on disputed facts for the judgment of a Board or jury, but is applicable general, Federal and local law as aforementioned.

In addition, the retention of the jury as a fact finding body is a constitutionally guaranteed right jealously guarded by our Courts. **Certiorari** has frequently been granted to assure its preservation.

In **Beacon Theaters, Inc. vs. Westover,** 79 S.Ct. 948, for example, Fox West Coast Theatres, Inc. had brought suit against Beacon seeking declaratory relief and injunction. Beacon had invoked the Anti-Trust Acts seeking treble damages. The District Court had denied Beacon with jury trial.

This Honorable Court granted certiorari on the following basis:

"Maintenance of the jury as a fact-finding body is of such importance and occupies so firm a place in our history and jurisprudence that any seeming curtailment of the right to a jury trial should be scrutinized with the utmost care. **Dimick vs. Schiedt**, 293 U.S. 474, 486; 55 S.Ct. 296, 301; 79 L.Ed. 603."

"Since the right to jury trial is a constitutional one, however, while no similar requirement protects trials by the Court, that discretion is very narrowly limited and must, wherever possible, be exercised to preserve jury trial."

In this cause, too, these points, buttressed by the others aforesaid, should assure that certiorari be granted.

At the very least, it can be said in this cause that the United States Court of Appeals for the Fifth Circuit has denied the Petitioner both a jury trial and a judge trial and has acted itself in this cause as trier of the facts and arbiter of the law. This is fundamental error and your Petitioner is here seeking certiorari to correct it.

CONCLUSION

The United States Court of Appeals, Fifth Circuit, in this cause, incorrectly interpreted and extended the language of Florida Statute 627.01081, as well as applicable local case law, and said interpretation and extension conflict with the Florida Supreme Court in **Permenter**, and incorrectly expand the holding of the Florida Supreme Court in **Shifflet**. Thus, it is a question of great importance to the People of Florida and in the public interest, to have this question set right by the Supreme Court of the United States.

Additionally, if said Court of Appeals found the Trial Judge to have erred in directing a verdict for Petitioner, it should not have substituted its own findings of fact for those of a jury to which the Petitioner is entitled by the United States Constitution where issues of fact exist.

The disputed questions of fact surrounding the insured's knowledge, on February 3, 1970, of the seriousness of his impairment of health in this case, are for a jury's decision.

As Godbold, J., stated, dissenting in the denial of the Petition for Rehearing in the United States Court of Appeals, if, the Appellate Court correctly held that the distinguished Trial Judge erred in directing a verdict for the Petitioner, then what remained in the case was a question of fact for jury determination and the Appellate Court should have remanded the case for trial to the United States District Court for the Southern District of Florida.

For these reasons, a writ of certiorari should issue to review the judgment and opinion of the Court of Appeals for the Fifth Circuit, to order said judgment vacated, to either reinstate the judgment of the Trial Court, or to remand for jury trial, or for other action as appropriate.

Respectfully submitted,

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APPENDIX A

IN THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 71-2258

DISPOSABLE SERVICES, INC.,
Plaintiff-Appellee,

versus

ITT LIFE INSURANCE COMPANY OF NEW YORK,
Defendant-Appellant.

Appeal from the United States District Court for the Southern District of Florida

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(December 30, 1971)

Before BELL, AINSWORTH and GOLDBOLD, Circuit Judges.

AINSWORTH, Circuit Judge: Appellee, Disposable Services, Inc., brought this Florida diversity action as owner and beneficiary, of an insurance policy issued by ITT Life Insurance Company of New York on the life of Samuel Lee Britt, secretary of appellee corporation, after refusal by ITT to pay the proceeds following the death of Britt. The case was tried to a jury. Both parties moved

for a directed verdict and at the close of all the evidence, the Court directed a verdict in favor of plaintiff, Disposable Services, Inc. We reverse.

In November 1969, Britt applied to ITT for a policy of life insurance in the amount of $75,000 and designated Disposable Services, Inc. as owner and beneficiary. In the written application Britt's answers to questions therein indicated that he was in good health, and that he had no physical or mental disorder. He stated in the application that the only time he had consulted a physician in the preceding five years was for treatment of a bee sting; that the only surgical operation he had undergone was an appendectomy in 1954; that he had never had, or had been advised to have, any x-rays or other tests with the exception of a chest x-ray when he was in the United States Army in 1952; and that he had never been told that he had kidney stones or any kind of kidney disease, tumors or cancer. Britt submitted to a medical examination by a physician designated by ITT. The application for insurance was approved by ITT on December 11, 1969, and shortly thereafter Policy No. 21576, dated December 9, 1969, was mailed to Disposable Services in Florida. A clause in the policy provided that the policy would not take effect until "delivered and the first premium paid during the lifetime of the insured."

On or about the first of January 1970, Britt began experiencing discomfort and pain in his lower back. At about this time he also suffered a weight loss. On February 3, 1970, Britt consulted Dr. Henry H. Bryant relative to his complaints. The doctor examined him and found a tenderness over the kidney area. He informed Britt that he thought that a kidney stone was the cause and that this

would require hospitalization for further examination. Two days later, on February 5, 1970, Britt entered the hospital. On February 6, x-rays were made which showed obstructions in the kidney and colon. Britt was informed at that time of these findings as well as of the probability that he would lose his kidney, and he agreed to surgery. On February 8, Britt knew that cancer of the colon was very likely.

On February 9, 1970, ITT received a check to its order drawn by Disposable Services, and signed by Britt and another officer of the corporation, in the sum of $558.16, representing the first premium payment on the insurance policy. The check for payment was dated February 5 and apparently mailed on or about that date. The check was deposited for collection by ITT on February 10 and paid by the bank on February 13.

On February 10, Britt underwent surgery at which time it was definitely established that he was suffering from cancer which had spread through the abdomen and was obstructing the kidney and colon. On February 11, Britt was told that he had a tumor and that his kidney had been removed. Either on that day or shortly thereafter Britt was informed that the tumor was malignant. Britt died on May 24, 1970, as a result of the malignancy.[1]

In directing a verdict for appellee, the District Judge was of the opinion that inasmuch as the policy did not

[1]According to the hospital records, the final diagnosis was: "Carcinoma of the abdomen either from the sigmoid or from the pancreas with multiple metastases throughout the peritoneal surfaces including obstructive lesions in the small bowel and in the distal ileum and obstructing lesions in the area of the cecum and ascending colon."

contain a specific clause requiring that the insured be in good health at the time the policy became effective, Britt was under no duty to inform ITT of the change in his physical condition, and absent that duty, plaintiff was entitled to recover. We do not agree with the Trial Court.

Under the terms of the contract, the policy was not to take effect until the first premium was paid. Much controversy exists over two questions, first, whether Britt knew he had cancer prior to the time of the first premium payment and second, the actual date of the premium payment—ranging, according to the parties' contentions, anywhere from February 5, the date of the check for first premium, to February 13, the date on which the check was paid by the bank. However, it is unncessary to resolve either of these disputes in the disposition of the case. It is undisputed that on February 3, Britt was informed by Dr. Bryant that, in his professional opinion, Britt was suffering from some type of kidney ailment, probably a kidney stone, which required hospitalization for additional tests. The ITT representative testified that this condition alone would have caused ITT to reject the first premium check, and thus the contract would not have been consummated.[2] Because of the failure of Britt to disclose that

[2]The assistant vice-president in charge of underwriting insurance for ITT testified that his duties as an underwriter are to select and classify risks for life insurance. His answer to the following hypothetical question shows that ITT would have rejected the premium check if it had known the state of Britt's health when payment was made:

> "Q. Let us assume on February 3, 1970, you knew that Mr. Britt had gone back to see Dr. Bryant and had complaints of pain in his back for four or five days; that further he had told Dr. Bryant that he had a twelve-pound weight loss for the past few months; and that also he hadn't been feeling well. Let us assume further that you knew that Dr. Bryant had continued examination of Mr. Britt, as a result of which he found that there was a certain tenderness in Mr. Britt's left flank. Let us assume further that this may or may not have

representations made in his application for insurance were no longer true when the policy became effective on receipt of first premium payment, which changes if known by the insurance carrier would have caused it to refuse coverage, ITT is entitled to a judgment on the policy as a matter of law.

In the leading case of Stipcich v. Metropolitan Life Ins. Co., 277 U. S. 311, 48 S. Ct. 512 (1928), the issue before the Supreme Court was whether an applicant for life insurance owed a duty of informing the insurer of a material change in his health; which occurred subsequent to completion of the application for insurance but prior to the effective date of the policy. The Court answered in the affirmative and gave the following reasons for compelling full disclosure by the insured:

> "Insurance policies are traditionally contracts uberrimae fidei and a failure by the insured to disclose conditions affecting the risk, of which he is aware, makes the contract voidable at the insurer's option. [Citations omitted.]

---

suggested itself as kidney stones at the time, not taking into account anything else. Let us assume further that Dr. Bryant advised Mr. Britt to go into South Miami Hospital for tests. What would be your action or what would your action have been on February 9, when you received this check? . . . What would be or what would your action have been?
"A. I wouldn't have accepted the check.

"Q. Why not?
"A. Because you would have to find out exactly what the problem was. It could be anything. It could be kidney disease and what not. Therefore, I would have to know he is not in as good health as he was at the time of the exam, so I would have to decline or I would have to send the check back and perhaps look at it later, after I found out what the diagnosis was."

"Concededly, the modern practice of requiring the applicant for life insurance to answer questions prepared by the insurer has relaxed this rule to some extent, since information not asked for is presumably deemed immaterial. [Citations omitted.]

"But the reason for the rule still obtains, and with added force, as to changes materially affecting the risk which come to the knowledge of the insured after the application and before delivery of the policy. For even the most unsophisticated person must know that, in answering the questionnaire and submitting it to the insurer, he is furnishing the data on the basis of which the company will decide whether, by issuing a policy, it wishes to insure him. If, while the company deliberates, he discovers facts which make portions of his application no longer true, the most elementary spirit of fair dealing would seem to require him to make a full disclosure. If he fails to do so the company may, despite its acceptance of the application, decline to issue a policy, [citations omitted] or, if a policy has been issued, it has a valid defense to a suit upon it. [Citations omitted]." 277 U. S. at 316, 317, 48 S. Ct. at 513, 514.[1]

[1]The Florida Supreme Court approved principles of law similar to those in Stipcich in the case of Massachusetts Bonding & Ins. Co. v. Hoxie, Fla., 1937, 176 So. 480. Hoxie involved indemnity insurance policies where the insured had concealed the fact of an accident which had antedated reinstatement of policies previously lapsed for nonpayment of premiums. In Hoxie the Florida Supreme Court quoted with approval the following pertinent language from Whitley v. Piedmont & Arlington Life Insurance Co., 71 N.C. 480:

Britt thus had a duty to inform ITT of the impairment of his health and to disclose the details thereof. His failure to do so provided a valid defense to ITT in this suit on the policy.

"A Policy of Life Insurance is not binding until the premium is paid—such a clause being contained in the application. And it is the duty of the assured to communicate to the Company, any material change in his health, in the interval between the application and the completion of the contract by the payment of the premium." (Emphasis supplied.) 176 So. 482.

Our subsequent decision in Wilkins v. Travelers Ins. Co., 5 Cir., 1941, 117 F.2d 646, is not to the contrary and the principles of Stipcich and Hoxie were properly distinguished on the facts.

The principles in Hoxie relative to the duty to disclose are in accord with leading authorities on insurance. Couch states that:

"Known changes in conditions material to the risk which occur between the opening of negotiations for insurance and the issuance of the policy must be divulged. That is, there is a continuing duty on the part of an applicant to disclose newly discovered matters arising between the application for, and the confirmation of, the contract where they come to the applicant's knowledge and render his former answers no longer true.

• • •

"The mutual good faith which is required in a contract of life insurance will not permit a recovery where the insured intentionally withholds or conceals material changes in the condition of his health between the date of his examination by the insurer's physician and the delivery of the policy and which is of such a nature as to affect his insurability, make him a hazardous risk and thus amount to a fraud on the insurer." 9 G. Couch, Couch on Insurance 2d, §§38.21-2 at 346-7.

Appelman states the principle in the following language:

"The rule is that the insured must inform the company of any change in his physical condition of which he becomes cognizant after making application for the policy and prior to the delivery thereof. This duty to disclose any change of health exists regardless of whether there is a provision in the policy requiring such disclosure. 1 J. Appleman, Ins. L. & P., §210 at 355.

Under Florida statutory provisions it is clear that considering the circumstances here there can be no recovery on the policy. Florida Statute 627.01081, F.S.A., provides:

> "Representations in applications — All statements and descriptions in any application for an insurance policy or annuity contract, or in negotiations therefor, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless either:
>
> "(1) Fraudulent; or
>
> "(2) Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or
>
> "(3) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate, or would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise." (Emphasis supplied.)

Appellee contends that Britt acted in good faith and that he had no knowledge of the seriousness of his illness. However, bad faith is only one of several grounds under the Florida statute above cited for vitiating an insurance

policy. The Florida Supreme Court held in Life Insurance Company of Virginia v. Shifflet, Fla., 1967, 201 So.2d 715, in answer to a certified question by this Court (see 5 Cir., 1966, 359 F.2d 501), the following:

> "We hold misrepresentations in an application for insurance material to the acceptance of the risk, do not have to be made with knowledge of the incorrectness and untruth to vitiate the policy." (Emphasis supplied.). 201 So.2d at 719.

The Florida Supreme Court further held:

> "We accord the statute its plain and obvious meaning and hold recovery under the policy is precluded if the misrepresentation is material to the acceptance of the risk or if the insurer in good faith would not have issued the policy in the terms it was issued." (Emphasis supplied.) 201 So.2d at 719.

Knowledge of the assured of an actual misrepresentation is therefore unnecessary to vitiate the policy under the express holding of Shifflet. See McDonell v. New England Mutual Life Insurance Company, 5 Cir., 1967, 380 F. 2d 983; Wissner v. Metropolitan Life Insurance Company, 5 Cir., 1968, 395 F.2d 204; Allstate Insurance Company v. Winnemore, 5 Cir., 1969, 413 F.2d 858.

Appellee contends, however, that Shifflet has been repudiated by the Florida Supreme Court in National Standard Life Insurance Co. v. Permenter, Fla., 1967, 204 So.2d 206. The Court in Permenter by per curiam discharged a writ for lack of jurisdiction. In a separate

concurring opinion, however, with which a majority of the Court agreed, Justice Ervin took the opportunity to state his views regarding the Shifflet decision. After expressing concern that the "pronouncement in Shifflet may be too sweeping in scope and might lend itself to application where literally to do so would work injustice," Justice Ervin said:

> "An incorrect statement in order to be material and vitiate a policy must be one given by the insured in response to a question he understood or reasonably should have understood, or one which reasonably he could be expected to have sufficient information to answer or state he lacked knowledge to give a responsive answer.
>
> • • •
>
> "Each situation where an alleged misrepresentation or incorrect statement is advanced to vitiate a policy should be examined to determine whether under the particular circumstances the applicant reasonably could be held responsible for the incorrect statement and without fault on the part of the insurer."[4] 204 So.2d at 206, 207.

We need not decide whether the holding in Shifflet has been narrowed by what is apparently dicta in Permenter. Under either the express holding in Shifflet, or the case-by-case approach in Permenter, recovery under the policy would be precluded if the insured failed to disclose the impairment of his physical condition, known to him from information supplied by his physician, after making his

[4]See also Tucker v. Travelers Insurance Company, Fla. App., 1970, 233 So.2d 198, in which the Florida Court of Appeal for the Fourth Circuit applied the more liberal standards suggested in Permenter.

written application and before payment for first premium was received. Non-recoverability under the Florida statute is not predicated solely on misrepresentations made in the application. Any such misrepresentation, omission, concealment of fact or incorrect statement occurring at any time during the period of negotiations between the parties operates to preclude recovery if any of the conditions shown in Sections (1) through (3) of the quoted Florida statute exists. Until the first premium was paid the parties were still legally in the process of negotiating. Either party could have withdrawn from the contract prior to that date. On February 3, at least two days before the contract under its own terms could have become effective, Britt became aware of a serious change in his physical condition which rendered several of his statements relative to his health, no longer true. Britt was not only the potential insured under the policy. He was also an officer of appellee corporation, the owner-beneficiary of the policy, and in such capacity he personally signed the premium check dated February 5. His failure to inform ITT of his physical condition as he was aware of it on February 3 and later—whether such failure is characterized as a passive misrepresentation, omission or concealment of fact—vitiated the policy under the Florida statute inasmuch as his condition was one material to the acceptance of the risk and because of which condition ITT would have refused coverage at that time if it had known about it.

For the foregoing reasons we hold that ITT was entitled to a directed verdict as a matter of law and the District Court should have so found.

REVERSED AND RENDERED.

APPENDIX B

IN THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 71-2258

DISPOSABLE SERVICES, INC.,
Plaintiff-Appellee,

versus

ITT LIFE INSURANCE COMPANY OF NEW YORK,
Defendant-Appellant.

Appeal from the United States District Court for the Southern District of Florida

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(April 13, 1972)

Before BELL, AINSWORTH and GODBOLD, Circuit Judges.

PER CURIAM: IT IS ORDERED that the petition for rehearing filed in the above entitled and numbered cause be and the same is hereby DENIED.[1]

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[1]In the motion for rehearing plaintiff complains of our conclusion that deceased, Britt, was advised on February 3, 1970 that a kidney stone was the cause of the pain in his back and that this would require hospitalization for further examination. Petitioner contends that Dr.

GODBOLD, Circuit Judge, dissenting to order denying petition for rehearing:

After considering the petition for rehearing and giving further study to the record, I think the petition should be granted.

The trial judge decided the case for plaintiff on a question of law. We held that he erred and then decided for defendant on another issue of law. I think the record reveals that, after all, what we have is a question of fact for jury determination.

Bryant's testimony is opposed to the Court's conclusion. No mention is made by petitioner, however, of defendant's Exhibit 2, identified in the record as "Hospital Admissions Records of Samuel Britt, South Miami Hospital, on February 5, 1970," which was received in evidence without objection (Tr. 51). One page of this exhibit (stamped page No. 360) shows at the bottom thereof, "DX (L) Kidney Stone, Dr. Bryant," indicating a diagnosis by Dr. Bryant of a left kidney stone. On the page entitled "History" (stamped page No. 322), dated February 5, 1970, information taken from the patient by Dr. Salazar, who is designated as "Physician Taking History" and is one of the resident doctors, the following is shown under "PRESENT ILLNESS":

> "Pt. states that about nine days ago he started [with] pain in the back (on the left). It was a sore in the beginning and it increased until being very strong. With heat pad it improved. Three days ago he saw his doctor and he thought that probably a kidney stone was the cause and he must be admitted." (Emphasis supplied.)

This page bears the signature of Dr. Salazar.

When Dr. Bryant testified he was asked about the hospital records and the diagnosis as follows (Tr. 129-130):

> "Q. Doctor, we notice in the hospital records in one of two places that there was some reference in the early information taken of a suggestion of kidney stones. Did you ever diagnose this man as having kidney stones?
>
> "A. No. However, when you get an obstruction you have to consider that in the ureter it is one of the most common reasons for an obstruction, which would be a kidney stone, and that particular site of his obstruction is one of the most common practices or common places, rather, for a stone to lodge.

The ultimate concern is whether Britt, the insured, had such knowledge of an impairment to his health as put on him a duty to report it to the insurance company. This brings us face to face with the question of what Britt learned of his condition from Dr. Bryant on February 3, a date which, under any version of the facts, was before the policy became effective. Dr. Bryant testified that at no time did he diagnose Britt as having a kidney stone, that he examined Britt and found him essentially normal except for tenderness over the left kidney, that he thought there was something with the kidney, either an obstruction or infection, and recommended to Britt that he check in to the hospital and find out the cause, and that at some point (the time of which is not fixed) he indicated a "possible" kidney stone.

"Q. The entry on the hospital records in the preliminary information that it was diagnosed as kidney stones would make some sense to some physicians?

"A. Well, I'm not sure what you are referring to. It depends on where it is.

"This is on the admitting sheet when I first admitted him, 'left kidney stone.' That was my admitting diagnosis at that time.

"Q. I am referring specifically to the document called 'History.'

"A. Oh. All right.

"Q. It says, 'Present illness.'

"A. This was written by one of the house officers, house doctors or residents. What I am referring to is his admitting diagnosis on the first entry, the first admission. It talks about the left kidney stone. The resident frequently goes by the admitting diagnosis.

"Q. In other words, at some point you indicated possible kidney stone; is that it?

"A. Yes. This area is the most likely area because of an obstruction to the kidney." (Emphasis supplied.)

In our view the record (including exhibits as well as testimony) sustains the conclusions we reached in our original opinion.

An entry on the hospital admission record, made by a resident physician who did not testify, said this:

> Pt. states that about nine days ago he started [with] pain in the back (on the left). It was a sore [sic] in the beginning and it increased until being very strong. With heat pad he improved. Three days ago he saw his doctor and he thought that probably a kidney stone was the cause and he must be admitted.

The entry is ambiguous—whether the second "he" is the doctor or Britt is unclear. In any event, ambiguous or not, taking both the hospital record and Dr. Bryant's testimony, it is plain that our original opinion was wrong in stating that it was "undisputed" that Dr. Bryant told Britt that he "was suffering from some type of kidney ailment, probably a kidney stone." (emphasis added).

It is for a jury to consider these post-event efforts to determine just how much Britt really knew on February 3, and, under appropriate instructions, to decide whether that knowledge was sufficient to require him to tell the insurance company about it.

APPENDIX C

IN THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

October Term, 1971

No. 71-2258

D. C. Docket No. 70-1317-Civ

DISPOSABLE SERVICES, INC.,
Plaintiff-Appellee,

versus

ITT LIFE INSURANCE COMPANY OF NEW YORK,
Defendant-Appellant.

Appeal from the United States District Court for the Southern District of Florida

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Before BELL, AINSWORTH and GODBOLD,
Circuit Judges.

JUDGMENT

This cause came on to be heard on the transcript of the record from the United States District Court for the Southern District of Florida, and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, reversed and rendered;

It is further ordered that plaintiff-appellee pay to defendant-appellant, the costs on appeal to be taxed by the Clerk of this Court.

December 30, 1971

Issued As Mandate: APR 21 1972